Jeffries Eye Associates

Allergies / Medications / Eye Health

MR#: _____
for office use

PLEASE COMPLETE IN BLACK OR BLUE INK

Patient: _____ **Date:** _____

DRUG ALLERGIES:

☐ Check if NONE

- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Latex

_____
_____
_____
_____

MEDICATIONS:

☐ Check if NONE

☐ See attached listing of medications

OR, please list below

Mediction Name - Include Non-prescription (OTC)

EYE HEALTH:

☐ NONE

- ☐ Cataracts
- ☐ Corneal Disease
- ☐ Flashes of Light
- ☐ Floaters
- ☐ Glaucoma
- ☐ Lazy eye / Amblyopia
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Other: _____

EYE SURGERIES:

☐ NONE

		Year
☐ Cataract Surgery	RT	
	LT	
☐ Laser Surgery - *List Reason*		
	RT	
	LT	
☐ Retinal Surgery - *List Reason*		
	RT	
	LT	
☐ Refractive Surgery - *Circle Type*	RT	
LASIK RK PRK LRI	LT	

List any EYE INJURY/ TRAUMA:

_____

_____

SOCIAL HISTORY:

Do you smoke or use tobacco?	**Yes**	**No**
Former Smoker?	**Yes**	**No**
Cigarettes?	**Yes**	**No**
How many? pack _____ per	**Day**	**Wk**
Do you drink alcohol?	**Yes**	**No**
Do you drink caffeine?	**Yes**	**No**

X _____

SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

Reviewed: _____